Georgia Department of Community Health

STATE HEALTH BENEFIT PLAN
NON-TOBACCO USERS AFFIDAVIT FORM

Policyholder/Plan Member Name_____

Social Security Number_____

Health Plan Options: (Circle One) **Indemnity, PPO, High Deductible Health Plan, Lumenos, Definity and HMOs: United, Kaiser Permanente, BlueChoice, Cigna,**

☐ I hereby certify that all covered members have not used any tobacco products within the past twelve months.

☐ I have completed a Health Risk Assessment Program with the above Health Plan.

☐ I have downloaded and read wellness information in an area that is of interest to me.

☐ I understand that as a State Health Benefit Plan member I have the responsibility to read the current Decision Guide and the Summary Plan Description of my chosen health benefit option.

☐ I understand it is my responsibility to access the Open Enrollment Website each year to make elections and answer the surcharge questions to prevent default surcharges.

I also understand that this document must be completed, **all boxes checked** and returned to my payroll benefit coordinator in order for the removal of the tobacco surcharge. The effective date of the change will be dependent upon the payroll schedule for my employer. No refund in premium(s) will be made for the previous deductions that included the surcharge amounts. IRS rules require all premium charges to be prospective.

Signature_____ Date_____

Note: Once you have read and signed this affidavit you must submit it to your payroll location/benefit coordinator to have the below required deduction information completed.

Department/School System Use Only		
Payroll Location #	***Date of first deduction**	**Deduction Amount**

***Retro deductions will <u>NOT</u> be refunded. Only accept forms with all boxes checked.**